

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2011	
NAME OF PROVIDER OR SUPPLIER WATERS OF JASPER				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DRIVE JASPER, IN47546			
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F0000	<p>This visit was for a Recertification and State Licensure survey. This visit resulted in an extended survey, immediate jeopardy.</p> <p>Survey dates: February 15, 16, 17, 18, and 22, 2011 Extended survey dates: February 23, 24, 2011</p> <p>Facility number: 000314 Provider number: 155478 Aim number: 100274210</p> <p>Survey team: Terri Walters RN TC Carole McDaniel RN Martha Sauls RN 2/15 /2/16, 2/17, 2/18, 2/22, 2011 Elizabeth Harper RN 2/15, 2/16, 2/17, 2/18, 2/22, 2011</p> <p>Census bed type: SNF/NF: 62 Total: 62</p> <p>Census payor type: Medicare: 5 Medicaid: 45 other: 12 Total: 62</p>			F0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 15 Supplemental Sample: 4 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 2-25-11 Cathy Emswiller RN						

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F0250 SS=D	<p>Based on interview and record review, the facility failed to ensure behaviors were identified, monitored and/or tracked for 1 of 1 residents reviewed with behaviors on the ACU (Alzheimer's Care Unit) in a sample of 15 and 1 of 1 residents reviewed as being a victim of another resident's behavior in a supplemental sample of 1. Resident #59, Resident #60</p> <p>Findings include:</p> <p>1. The clinical record of Resident #59 was reviewed on 2/16/11 at 9 A.M. Diagnoses included, but were not limited to, the following: Vascular Dementia, Alzheimer's with Behavioral Disturbances and Psychiatric History. The most recent MDS (minimum data set assessment) dated 2/4/11, included, but was not limited to, the following for the resident: The resident's interview summary score totaled 3 severe cognitive impairment; Behavior: physical behav (behavior) symptoms directed toward others: behavior of this type occurred 1 to 3 days; verbal behavioral symptoms directed toward others: behavior of this type occurred 1 to 3 days; other behav symptoms not directed toward others: behavior of this type occurred 1 to 3 days; overall presence of behavioral symptoms:</p>			F0250	<p>The facility's intent is to ensure resident behaviors are identified, monitored and/or tracked on a daily basis. Actions taken to correct:</p> <p>Behavior Monitoring Records put in place for residents # 59 and # 60.</p> <p>How others were identified:</p> <p>100% audit was completed for all residents with identified behaviors to ensure a behavior monitoring record in place, with the appropriate interventions. No other residents were identified.</p> <p>Measures taken to correct:</p> <p>SSD/Designee will review all new admissions at the time of admission for any behaviors previous to admit and initiate behavior monitoring records as needed. All staff will be re-inserviced on behavior management program and appropriate documentation on the behavior log on March 17, 2011.</p> <p>How it will be monitored:</p> <p>The Social Service Director and the Program Manager for the Alzheimers unit will review/audit the chart of any resident with an identified behavior/assessment referral form and report status</p>		03/17/2011

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	<p>"yes", Behav (behavior) symptoms intrude on privacy of others "yes."</p> <p>For Functional Status, the MDS indicated the following: "Walk in corridor - self performance: self performance - supervision (oversight, encouragement or cueing); walk in corridor: support provided - set up help only; locomotion on unit: self performance - supervision - oversight, encouragement or cueing; locomotion on unit: support provided - set up help only."</p> <p>During initial tour of the facility on 2/14/11 at 9 A.M., Resident #59 was observed housed on the facilities' secured, Alzheimer's Unit.</p> <p>Nurses notes, dated 1/20/11, indicated the following at 1800 (6 P.M.): "...cont. on down hall with sl. unsteady gait while using cane. Noticed resident not in hall, discovered him in another rsd (resident) room. Tried to talk him into visiting his own room - became agitated yelling "Get out of here (swear word). grabbed this nurse's hand, grabbed at SSD et swung cane. Able to remove cane after many minutes. Phoned (resident physician) he advised to just keep him away from other rsd et his mood would change just as quickly as it began."</p>				<p>during daily QA stand up meeting.</p> <p>Social Service Director/Program Manager/Designee will review/audit the plan of care initiated and effectiveness of interventions in weekly PAR meeting.</p> <p>Administrator/Designee will review audits in quarterly QA meeting with Medical Director for on-going compliance. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is: 3/17/11.</p>		

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	<p>On 2/18/11 at 11 A.M., the SSD (social service director) was interviewed. She indicated these behaviors (as documented on 1/20/11 at 6 P.M.) were not logged on a behavior form as the resident had only been here a few hours and this was not a "patterned behavior."</p> <p>Nurses notes, dated 1/21/11 at 2 P.M. "...mood change in from cooperative to "grumpy" intermittently."</p> <p>Nurses notes, dated 1/23/11 at 10 P.M., indicated the following: "Res been wandering in et (and) out of other resident's rooms...Spits in other residents trash cans..."</p> <p>Nurses notes, dated 1/23/11 at 11 P.M. "Res wandering into other res (resident's) rooms. Checking closet doors...checking bathrooms out...confused et becoming agitated...ambulated in hallway with standby assist, getting more agitated, more resistive...Res stomped on CNA (certified nursing assistant) foot et (and) squeezed QMA (qualified medication assistant) r (right) hand, scratching QMA finger, tried to pull right thumb back..."</p> <p>Nurses notes, dated 1/24/11 at 8:50 A.M.: "...Urinated all over floor..."</p>						

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	<p>Nurses notes, dated 1/24/11 at 11:30 A.M.: "...allowed nurse to assist to bed then pointed (poked) nurse in chest and stated "Get the (swear word) out of here, I'm in charge here..."</p> <p>The MDS 3.0 Social Service Progress Note, was dated 1/24/11. This form included, but was not limited to, the following: "Res shut co res. door to room, res physically abusive to staff, verbally abusive. Res becomes very easily annoyed." Psychoactive medications and diagnoses to support: "Agitation, psychosis, Alzheimer's dementia with behav...dx lexapro, namenda..."</p> <p>Physician office notes, dated 12/25 (10) indicated the following prior to the resident's admission to the facility: "Choked a caregiver. Happened at shift change, so this was witnessed. (Resident name) convinced himself that caregiver was stealing money, which prompted the attack...."</p> <p>A physician office note, dated 1/3/11, indicated the following for the resident: "...assaulted an in-home care giver 12/25. Psychiatric inpatient stay early January. Some throwing punches at staff there but</p>						

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	<p>typically was easily redirected..."</p> <p>A plan of care, dated 1/11, indicated the following: "Physically Abusive. " Interventions included, but were not limited to, the following: Allow resident to voice feelings, re approach at a later time, calm environment, introduce self et explain intent, speak in calm voice, speak to res about baseball, approach with diff care giver, firm, direct approach."</p> <p>A plan of care, dated 1/11, indicated the following: "Special care unit placement needed due to increased confusion secondary to dx (diagnosis) of dementia."</p> <p>A plan of care, dated 1/11, indicated the following: "Cognitive deficit: disordered thinking/awareness, not of recent onset r/t (related to) dementia." Interventions included, but were not limited to, the following: "monitor for changes or decline in cognitive status."</p> <p>A plan of care, dated 1/11, indicated the following: "Psychotropic medications.." Interventions included, but were not limited to, the following: "Monitor for behavior et (and) document if any."</p> <p>A social service note, dated 1/20/11 indicated the following: "...Became</p>				

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	<p>agitated with staff et re-direction..." On 1/24/11" Res behavior cont (continue) over weekend. Res. had to be given PRN Abilify on 1/23/11...Res very combative with staff et unable to re-direct. Res given space but did not help with behavior. Res upsetting co-res. Res given PRN Abilify today...1/24/11 Res. attempted to kick this SSD in face when helping res into facility bus. Male staff was able to re-direct res. et assist him to sit down et apply seatbelt. Res transferred to (behavior hospital name). 2/3/11: Res had behaviors in noc (night). Behavior monitoring record started."</p> <p>Nurses notes, dated 2/1/11 at 3 P.M. indicated the following: "SSD called for assistance with res. Resident in (room number of another resident) and did not want to come out...questioned need to toilet. Res (resident) picked up wet floor sign et (and) hit this nurse on bottom with it et SSD..."</p> <p>Nurses notes, dated 2/3/11 at 6 A.M., indicated the following: "Res has been up all noc (night) wandering in et out of other res's rooms. Increasing agitation each time we explain to res why he cannot go into other res rooms, continues to do so...Res grabbed CNA r arm...this QMA said firmly "Do not go in that room." Res</p>						

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	<p>turned around et shoved this writer into hallway bench. CNA attempted to calm res et res shoved her into a wheelchair. Then res proceeded toward another res who was sitting in a w/c (wheelchair) in hallway. This res started poking his finger in other res shoulder hard several times and then grabbed other res arm. CNA witnessed this et had separated res..."</p> <p>On 2/17/11 at 10:45 A.M., a copy of the "Behavior Monitoring Record" for January and February 2011 were received from the ADON. The SSD was interviewed at this time and indicated the resident did not have any behaviors logged for the month of January 2011. Documentation was lacking of January Behaviors. For the month of February the following dates had logged behaviors: 2/3/11 at 6:05 A.M., 2/10/11 at 10:30 P.M. and 2/15/11 at 9:15 A.M.</p> <p>On 2/17/11 at 11:40 A.M., the SSD (Social Service Director) was interviewed. She indicated she is also the unit Manager for the Alzheimer's Dementia unit. The SSD indicated they will watch to see if the behavior continues or not or if the behavior is a "one time thing." They look at the time of day, pattern etc. The SSD indicated the facility team looks at</p>						

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	<p>the resident's actions to determine if it is a behavior or not. Once the resident is determined by the facility team to have "behaviors", the behaviors will then be logged. She indicated when a behavior occurs, staff fill out a behavior monitoring sheet and then give it to the SSD. The SSD indicated at this time, the resident who was the recipient of Resident #59 poking him with his finger was resident #60.</p> <p>On 2/17/11 at 12:50 P.M., the SSD provided a current copy of the facility policy and procedure "Behavior Program Policy and Procedure." This form was dated 11/10. This form included, but was not limited to, the following: "...will monitor residents who exhibit: Behavior symptoms which constitute a source of distress for the resident or represents a threat of danger to the resident or others, regardless of the resident's diagnosis...Behaviors that violate the rights of others..." "Procedure:...1. An evaluation or new or worsening behavior form..shall be completed when the observed behavior is new or worsening, sub</p> <p>2. On 2/17/11 at 1 P.M., the clinical record of Resident #60 was reviewed. Diagnoses included but were not limited</p>						

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	<p>to the following: Alzheimer's Dementia, Anxiety state, Episodic Mood Disorder and Psychosis. The MDS Assessment dated 1/7/11 indicated the following for the resident: severe impaired cognition; resident showed little interest or pleasure in doing things, trouble falling or staying asleep or sleeping too much, trouble concentrating on things...being short tempered, easily annoyed..."</p> <p>On 2/17/11 at 11:40 A.M., the SSD (Social Service Director) was interviewed. She indicated Resident #60 was the recipient of Resident #59's finger poking on 2/3/11 at 6 A.M.</p> <p>Social Service notes, dated 2/15/11 indicated the following: "Res being very restless, anxious..."</p> <p>Social Service notes, dated 2/15/11, indicated the following: "Spoke with res. family today in r/t (relation to) res. increase agitation, restlessness. Res. given 1:1 by staff at times..."</p> <p>The Behavior Monitoring Record for February 2011 was received from the DON on 2/18/11 at 10:20 A.M. This form identified one behavior of "restlessness, increased anxiety." The form was blank, with no behaviors</p>						

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	<p>logged.</p> <p>Nurses notes, dated 2/1/11 at 0100 (1 A.M.) indicated the following: "...Sx's (symptoms) of anxiety, Ativan prn dose given..."</p> <p>Nurses notes, dated 2/11/11 at 10:15 (A.M.) indicated the following: "Res continues with above aforementioned behaviors. Attempted to toilet...PRN ativan given, will monitor."</p> <p>Nurses notes, dated 2/12/11 at 11:45 A.M. indicated "...Res cont (continue) to be agitated..."</p> <p>Nurses notes, dated 2/13/11 at 10 A.M., indicated "...Restless..."</p> <p>Nurses notes, dated 2/16/11 at 12:45 P.M. indicated: "Restless. Staff toileted et ambulated. Rsd continues to be anxious...will cont to monitor."</p> <p>Nurses notes, dated 2/17/11 at 12:30 P.M. indicated: "Res. given prn ativan d/t increased agitation..."</p> <p>Nurses notes, dated 2/17/11 at 1:30 P.M., indicated "...continues to be restless..."</p> <p>The Plan of care, dated 4/10, indicated the</p>						

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	following: "Psychotic medications." Interventions included, but were not limited to, the following: "Monitor for behavior et document if any..." The plan of care, dated 4/10, indicated the following: "Anxiety AEB Restlessness." Interventions, included but were not limited to, the following: "...offer support/reassurance..." Documentation was lacking on the behavior log of the resident's behaviors as noted in the nurses notes and the social service notes . 3.1-34(a)						

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F0253 SS=C	<p>Based on observation and interview, the facility failed to maintain/replace worn wallpaper and repaint chipped surfaces in common areas of the facility interior on 3 of 3 units on 2 of 5 days surveyed.</p> <p>Findings include:</p> <p>1. On 2-17-11 at 10:20 A.M., the dining room/kitchen door entry jam was noted to be chipped and discolored. The entry floor and around the jam was brown in color.</p> <p>2. On 2-17-11 at 10:20 A.M., the wallpaper in the main dining room was noted to be missing and torn in different areas throughout the dining room leaving a tan color on the wall. Areas are as follows:</p> <p>a) Beside the service window, above and over the kitchen entry door.</p> <p>b) Wallpaper was missing on the</p>			F0253	<p>F253 Housekeeping & Maintenance Services It is the intent of this facility to maintain/replace worn wallpaper and repaint chipped surfaces in common areas of the facility interior.</p> <p>Actions taken to correct:</p> <p>The dining room/kitchen door entry has been repainted. The entry floor and around the jam have been cleaned.</p> <p>The wallpaper in the dining room has been removed and the dining room has been painted.</p> <p>There is no service window above and over the kitchen entry door. The baseboard heaters have been removed.</p> <p>The flooring on the Memory Care Unit has been stripped and re-waxed.</p> <p>The missing piece of laminate flooring at the entrance of the small kitchenette has been replaced.</p> <p>The flooring from the entrance to the therapy department has been replaced with new flooring.</p> <p>The section of flooring on the 100 unit has been replaced.</p> <p>How others were identified:</p> <p>No residents were affected.</p> <p>Measures taken to correct:</p> <p>The Preventative Maintenance program will address these or any</p>		03/25/2011

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	<p>long solid wall under the plug in outlet and by the double door closet (three squares by two squares) of design in the wallpaper and near the bottom of the Arch design had four areas of missing wallpaper.</p> <p>c) Behind the trash container located near the kitchen door was an area of three squares missing wallpaper leaving a tan color visible.</p> <p>d) The wallpaper under the fifth window (from the bird cage) was ripped up two squares while still attached to the wall.</p> <p>3. The base board heaters along the wall under the windows was noted with multiple chipped paint areas.</p> <p>4. On 2-22-11 at 9:15 A.M., observation of facility flooring was noted to have multiple areas of darkened discolored areas throughout the building. Areas are as follows:</p>		<p>other issues through the weekly inspections which is a part of the Preventative Maintenance Program. Any area of concern will be addressed and corrected.</p> <p>How will it be monitored:</p> <p>The Maintenance Director and Administrator/Designee will audit the weekly inspections results to ensure completion of program. Review of the audits will be conducted during the Quarterly QA meeting with the Medical Director.</p> <p>This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is: 03/25/11</p>		

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	<p>a) The secured unit was noted to have stained areas between room 509 and 511 around the metal cover in the floor. The unit hallway near the shower room, dining room and Memory Lane sitting area had multiple darkened areas.</p> <p>b) The laminate flooring at the entrance of the small kitchenette was missing a backwards "L" shaped piece of the flooring.</p> <p>5. During Observation:</p> <p>a) On 2-22-11 at 9:35 A.M., indicated darkened stains near the Mechanical door and around the metal plate in the center of the hallway. The center floor near the copy room had missing tan flooring with two exposed dark gray areas.</p> <p>b) The flooring near the Therapy Services area across from the ice machine to across the hall by the</p>						

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	<p>Storage door was cracked the entire width of the hall.</p> <p>c) The flooring near the 100 hall dining room was noted to be cracked the entire width across the floor.</p> <p>6. An interview with the facility Administrator on 2-22-11 at 9:45 A.M., indicated the facility had been purchased by new owners and dining room and the facility floors were in the plans for changes to take place.</p> <p>3.1-19(f)</p>						

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F0328 SS=J	<p>Based on observation, interview, and record review, the facility failed to provide tracheal suctioning and proper routine tracheostomy care and/or provide preparation for emergency tracheostomy care for 1 of 1 residents with tracheostomy in a sample of 15 and 1 of 1 from a supplemental sample of 1 additional resident with a tracheostomy. Resident # 11 Resident #9</p> <p>This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 2/15/11. The Administrator and Director of Nursing were notified on 2/23/11 at 3:05 P.M. The Immediate Jeopardy was removed on 2/24/11 at 2:30 P.M., but the facility remained out of compliance at a level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. The Administrator will ensure the continued clinical support of a Respiratory Therapist for ongoing competency audits beginning with daily rotation shift monitoring for 2 weeks, and then 3 audits per week for one month decreasing to quarterly for 6 months. Ongoing reporting of results to the Director of Nursing and Administrator will continue until compliance standard maintenance is assured for tracheostomy care. The Director of Nursing/Designee</p>		F0328	<p>F328 Treatment/Care for Special Needs It is the intent of this facility to provide tracheal suctioning and proper routine tracheostomy care and/or provide preparation for emergency tracheostomy care for all residents with a tracheostomy.</p> <p>Actions taken to correct:</p> <p>Contracted with Respiratory company to provide a Therapist for ongoing clinical support. Respiratory Therapist completed a Respiratory Evaluation of resident #11. Emergency equipment was placed in resident #11 and #9 rooms, easily accessible for staff in an emergency. The following equipment is in room: Trach care kits, bottles of hydrogen peroxide, bottles of sterile H2O, sterile gloves in larger sizes, suction machine, suction cath-n-glove kit, inner cannulas, ambu bag, #6 cuffed tracheostomy tube, isolation gowns and masks to be used if any reasonable suspicion of coughing and splattering of mucus. In-service provided by Respiratory Therapist on 2/23/11 at 7:30 p.m. and on 2/24/11 in the a.m. In-service material covered by Therapist includes the following: Tracheostomy Care, Tracheostomy Suctioning, Tracheostomy Tube Change, Application and usage of Ambu Bag for Trach patient. Therapist</p>		02/25/2011	

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	<p>will complete random monitoring of handwashing/glove usage proficiencies for 5 staff daily to include all shifts within each week of the next 30 days, then 5 staff weekly including all shifts for 30 days then 5 staff randomly each quarter. All results will be reviewed at Quarterly Quality Assurance Meeting to ensure continued compliance.</p> <p>Findings include:</p> <p>1. The clinical record of Resident #11 was reviewed on 2/15/11 at 10:40 A.M. Diagnoses included but were not limited to, "Acute Renal failure, Anoxic Brain injury and sudden cardiac arrest." The Resident had been admitted one week earlier with severely impaired cognition, was not responding to verbal stimuli and was unable to voluntarily move. The resident had a tracheostomy and physician orders on 2/09/11 for trache care each shift and inner cannula change every day and Suction trache as needed and change trache monthly. The resident was to receive a Full Code in the event of arrest.</p> <p>The resident had been admitted from a hospital where she had been treated from 2/06/11 to 2/09/11 following a stay at another nursing home. The hospital</p>				<p>also utilized a mannequin and all licensed nurses performed a return demonstration.</p> <p>How others were identified:</p> <p>Respiratory Therapist completed a Respiratory Evaluation of resident #9. There are no other Trach patients.</p> <p>Measures taken to correct:</p> <p>In-service by Respiratory Therapist on 2/23/11 at 7:30 p.m. and on 2/24/11 in a.m. In-service material covered by Therapist includes the following: Tracheostomy Care, Tracheostomy Suctioning, Tracheostomy tube Change, Application and usage of Ampu Bag for Trach patient. Therapist also utilized a mannequin and all Licensed Nurses were required to perform a return demonstration. The facility has contracted with Respiratory company to provide a Therapist for ongoing clinical support. No Licensed Nurse will be allowed to provide tracheostomy care until in-serviced by Respiratory Therapist including completing satisfactory return demonstration.</p> <p>How it will be monitored:</p> <p>The Administrator/Designee will</p>		

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	<p>discharge Diagnoses indicated the resident had been treated in ICU for Sepsis of urinary and pulmonary source and acute respiratory failure secondary to mucous plugging and bilateral pneumonia. The 2/09/11 nursing admission assessment indicated the resident was totally dependent for all care and anticipation of needs and was non responsive to verbal stimuli.</p> <p>On 2/15/11 at 11:30 A.M. LPN #1 was observed as she began providing daily trache care and inner cannula change. The nurse indicated the resident was a "new trache," estimating it to have been in place about a month with stitch scars still fresh. The resident eyes were open but no tracking movements were present nor was she responsive to verbal stimuli. On interview at that time LPN#1 indicated she was aware the resident was to be Full Code in the event cardio resuscitation was required. She stated she did not know if the emergency ventilation Ambu bag would fit the trache or would need an adaptor. There was no emergency device in the room to maintain the airway in case of trache dislodgement. After the interview, LPN #1 proceeded directly with the care. She noted the resident had approximately a tablespoon of thick yellow mucous around the trache site on</p>				<p>receive from the Respiratory Therapist the following: The Respiratory Therapist will complete, for 1 week, clinical skills competency check off's to be completed on 1 shift each day with rotation of shifts for a period of 2 weeks. The Therapist will complete clinical skills competency check off's for 3 times with rotation of shifts for each week up to 30 days. The Therapist will complete clinical skills competency check off's with rotation of shifts every quarter. Then at 6 months will complete a quality assurance in-service with completion of clinical skills competency check off and return demonstration by all Licensed Nurses. Thereafter, an annual in-service and competency, at a minimum, will be provided to all licensed staff to maintain competency. These audits/competencies will be reviewed in the quarterly QA meeting with the Medical Director This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is: 2/25/11.</p>		

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	<p>the dressing pad and was coughing and gurgling. The LPN did not suction the resident or auscultate but directed the resident to "Cough it up. Go ahead that's right, caught it up. I like them to cough it up themselves." The resident spontaneously coughed for approximately 4 minutes and approximately 3 tablespoons were expelled. The nurse then opened the disposable sterile trache care set. She washed hands, donned sterile gloves which were too small, contaminating them in the process of trying to pull them on. She used the soiled gloves to remove the inner disposable trache cannula and then handled the sterile replacement cannula, guiding it in by holding the tube itself, rather than the exterior end. A brush was provided in the kit for use when cleansing the soiled inner cannula, before reinserting it into the resident, when a new one was not being used. Following tube replacement, the nurse took the cleaning brush, inserted it into the new cannula which was in the resident. She inserted it approximately 2 to 2.5 inches, wiggled it removed it for unknown rationale. The nurse indicated the facility did not have a respiratory therapist in house stating "We're it."</p> <p>The facility Policy and Procedure,</p>						

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	<p>effective 6/20/03, for Clinical standards of tracheostomy care was reviewed on 2/22/11 at 9:00 A.M. It directed the nurse or respiratory therapist to suction the resident if needed prior to the procedure. It also indicated the disposable inner cannula was to be replaced with a sterile inner cannula. It indicated the cleaning procedure with brush was to be utilized for nondisposable inner cannula's which had been removed for cleaning.</p> <p>The facility reference book provided at the nurses station was the Lippincott Manual of Nursing Practice 9th edition. It was reviewed on 2/22/11 at 9:44 A.M. It included "Nursing Care for Patients with Artificial Airways General Care Measures ...External Tube Site Care...3. Have available at all times at the patient's bedside a replacement ET (endotracheal tube) in the same size as the patient is using, resuscitation bag, oxygen source, and mask to ventilate the patient in the event of accidental tube removal. Anticipate your course of action in such an event..."</p> <p>The reference also included procedures for routine trache care on page 227. Excerpts included: "... 1. Suction the trachea and pharynx thoroughly before tracheostomy care...7. If disposable inner</p>						

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	<p>cannula is used, replace the new cannula...touching only the external portion to avoid contamination of the inner portion If inner cannula is reusable, remove it...clean using brush or pipe cleaners."</p> <p>On 2/16/10 at 8:15 A.M. CNA #1 and CNA #2 were observed caring for resident #11. The CNAs had just finished cleaning incontinent BM from the resident. With the same contaminated gloves, CNA #1 was wiping mucous from around the trache site dressing, using a corner of the towel which had been in use for the peri care. When informed of the possibility of cross contamination she indicated she was not familiar with the care of the resident, and applied new gloves to her unwashed hands. CNA#2 used gloves for the peri care, handled Foley catheter tubing and bag and then repositioned the respiratory misting unit tubing and mask over the trache.</p>						

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F0328 SS=J	<p>2. The clinical record of Resident #9 was reviewed on 2/15/11 at 1 P.M. Diagnoses included, but were not limited to, tracheotomy.</p> <p>On 2/16/11 at 2:30 P.M. the resident was observed in her room with a tracheotomy in place. No emergency supplies such as the inner cannula and/or ambu bag were observed in the resident's room.</p> <p>On 2/16/11 at 3 P.M., the DON toured the resident's room and was unable to locate any inner cannula's for the tracheotomy and/or an ambu bag readily available in the resident's room. She indicated she would place inner cannula's at the resident's bedside and an ambu bag.</p> <p>The Immediate Jeopardy began on 2/15/11, when the facility had failed to ensure minimum staff proficiencies of routine and emergency care and infection control for residents with tracheostomy. The Immediate Jeopardy was removed on 2/24/11 at 2:30 P.M. when through observation of practice, review of inservicing and interview, it was determined that staff were applying principles of safety and tracheostomy care within compliance. The facility had acquired clinical consultation with</p>			F0328	<p>F328 Treatment/Care for Special Needs It is the intent of this facility to provide tracheal suctioning and proper routine tracheostomy care and/or provide preparation for emergency tracheostomy care for all residents with a tracheostomy.</p> <p>Actions taken to correct:</p> <p>Contracted with Respiratory company to provide a Therapist for ongoing clinical support. Respiratory Therapist completed a Respiratory Evaluation of resident #11. Emergency equipment was placed in resident #11 and #9 rooms, easily accessible for staff in an emergency. The following equipment is in room: Trach care kits, bottles of hydrogen peroxide, bottles of sterile H2O, sterile gloves in larger sizes, suction machine, suction cath-n-glove kit, inner cannulas, ambu bag, #6 cuffed tracheostomy tube, isolation gowns and masks to be used if any reasonable suspicion of coughing and splattering of mucus.</p> <p>In-service provided by Respiratory Therapist on 2/23/11 at 7:30 p.m. and on 2/24/11 in the a.m. In-service material covered by Therapist includes the following: Tracheostomy Care, Tracheostomy Suctioning, Tracheostomy Tube Change, Application and usage of Ambu Bag for Trach patient. Therapist</p>		02/25/2011

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	Respiratory Therapy for ongoing compliance assurance in conjunction with monitoring and auditing by the Director of Nursing and Administration. 3.1-47(a)(4)				also utilized a mannequin and all licensed nurses performed a return demonstration. How others were identified: Respiratory Therapist completed a Respiratory Evaluation of resident #9. There are no other Trach patients. Measures taken to correct: In-service by Respiratory Therapist on 2/23/11 at 7:30 p.m. and on 2/24/11 in a.m. In-service material covered by Therapist includes the following: Tracheostomy Care, Tracheostomy Suctioning, Tracheostomy tube Change, Application and usage of Ampu Bag for Trach patient. Therapist also utilized a mannequin and all Licensed Nurses were required to perform a return demonstration. The facility has contracted with Respiratory company to provide a Therapist for ongoing clinical support. No Licensed Nurse will be allowed to provide tracheostomy care until in-serviced by Respiratory Therapist including completing satisfactory return demonstration. How it will be monitored: The Administrator/Designee will		

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					<p>receive from the Respiratory Therapist the following: The Respiratory Therapist will complete, for 1 week, clinical skills competency check off's to be completed on 1 shift each day with rotation of shifts for a period of 2 weeks. The Therapist will complete clinical skills competency check off's for 3 times with rotation of shifts for each week up to 30 days. The Therapist will complete clinical skills competency check off's with rotation of shifts every quarter. Then at 6 months will complete a quality assurance in-service with completion of clinical skills competency check off and return demonstration by all Licensed Nurses.</p> <p>Thereafter, an annual in-service and competency, at a minimum, will be provided to all licensed staff to maintain competency. These audits/competencies will be reviewed in the quarterly QA meeting with the Medical Director</p> <p>This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is: 2/25/11.</p>		

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F0431 SS=D	<p>Based on observation and interview, the facility failed to ensure narcotics were under double lock and secured from potential unauthorized access and the temperature in the refrigerators which housed medications was at the required temperature to ensure the medications were safe and affective on 2 of 3 facility units.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 2-22-11 at 12:35 P.M., the medication room on 300/400 hall was observed. The door was noted to be open and the narcotic box was unlocked in the refrigerator. An interview at this time with LPN # 3 indicated, "the pharmacy lady left 30 minutes ago and said she would lock the refrigerator narcotic box and the medication room when she left." 2. On 2-22-11 at 2:15 P.M., the medication room door was observed to be open. 		F0431	<p>F431 Drug Records, Label/Store Drugs & Biologicals The facility's intent is to ensure narcotics are under double lock and secure from potential unauthorized access and temperatures in refrigerators that house medications are at the required temperature to ensure they are safe and effective.</p> <p>Actions taken to correct:</p> <p>New refrigerator purchased for 500 unit med room. Narcotic box locked Med room door closed</p> <p>How others were identified:</p> <p>All other med room refrigerators were checked for proper temperatures and no problems found. All other med room doors were checked with no open doors found. All narcotic boxes were under double lock.</p> <p>Measures taken to correct:</p> <p>Temperatures will be recorded daily on all refrigerators to maintain the appropriate temperature. Licensed Nurses in-serviced to remain with Pharmacy Consultant while he/she checks narcotic box and ensure he/she locks narcotic box when finished; the importance of keeping the med room door closed so ensure all</p>		03/11/2011	

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	3. On 2-22-11 at 12:40 P.M., an observation of the medication refrigerator temperature read 32 degrees Fahrenheit. Medications present were, Aplisol 5TU/0.1 ml, label indicated to "store between 36 degrees Fahrenheit to 46 degrees Fahrenheit," and the emergency supply of Lorazepam 2 mg/ml label indicated, "do not freeze". The temperature control inside the refrigerator was increased by LPN # 5. 3.1-25(m) 3.1-25(n)				narcotics are double locked; and the importance of the appropriate refrigerator temperature for storage of medications the require refrigeration, on March 11, 2011. How it will be monitored: The D.O.N./Designee will monitor temperature log 3 times weekly to ensure proper temperature is maintained, this will be on-going. The IDT will check during daily rounds to ensure med room door is closed and locked at all times. The D.O.N./Designee will check narcotic box after pharmacy consultant monthly visit to ensure locked. Results will be reviewed during daily stand-up QA meeting and in the Quarterly Quality Assurance Meeting with Medical Director for on-going compliance. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is: 3/11/11.		

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F0441 SS=K	<p>A. Based on observation, record review and interview, the facility failed to ensure correct infection control practices were followed to prevent infections during dressing changes for 3 of 4 residents in a sample of 15. This deficient practice had the potential to impact 53 of 62 residents in the facility for whom staff provided care. Resident #11 Resident #26, Resident#45</p> <p>This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 2/15/11. The Administrator and the Director of Nursing were notified on 2/23/11 at 3:05 P.M. The Immediate Jeopardy was removed on 2/24/11 at 2:30 P.M., but the facility remained out of compliance at a level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. The Director of Nursing/Designee will complete random monitoring of hand washing/glove usage proficiencies [sic] for 5 staff daily to include all shifts within each week of the next 30 days, then 5 staff weekly including all shifts for 30 days then 5 staff randomly each quarter. All results will be reviewed at Quarterly Quality Assurance Meetings to ensure continued compliance.</p> <p>B. Based on observation, interview, and</p>			F0441	<p>F441 Infection Control, Prevent Spread, Linens</p> <p>The facility's intent is to ensure correct infection control practices are followed to prevent infections during dressing changes, and to ensure intravenous antibiotic medication solutions are provided after adequate handwashing.</p> <p>Actions taken to correct:</p> <p>All nursing staff were in-serviced on infection control, prevention of spread of infection, hand washing, and glove usage (including appropriate size), in relation to infection control.</p> <p>How others were identified:</p> <p>All residents would be at risk.</p> <p>Measures taken to correct:</p> <p>All nursing staff were in-serviced on infection control, prevention of spread of infection, hand washing, and glove usage (including appropriate size), not placing dressing supplies and/or bottles of medication in their pockets, appropriate use of hand sanitizer, etc., in relation to infection control with dressing changes and Intravenous medication solutions. C.N.A.'s were in-serviced on wearing gloves and hand washing. C.N.A.'s also in-serviced on proper</p>		03/01/2011

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	<p>record review, the facility failed to ensure Intravenous (IV) Antibiotic Medication solutions were provided after adequate handwashing for 1 of 2 residents observed for Antibiotic IV administration in a sample of 15. Resident #45</p> <p>Findings include:</p> <p>A.1. The clinical record of Resident #11 was reviewed on 2/15/11 at 10:40 A.M. The resident had a diagnosis of "Acute Renal failure, Anoxic Brain injury and sudden cardiac arrest." The Resident had been admitted one week earlier with severely impaired cognition, was not responding to verbal stimuli and was unable to voluntarily move. The resident had a tracheostomy and physician orders on 2/09/11 for trache care each shift and inner cannula change every day.</p> <p>On 2/15/11 at 11:30 A.M., LPN #1 proceeded to provide daily trache care and change the inner trache cannula and dressing. The nurse opened the disposable sterile trache care set. She washed her hands, donned sterile gloves which were too small, contaminating them in the process of trying to pull them on. She used the soiled gloves to remove the inner disposable trache cannula and then handled the sterile replacement cannula,</p>				<p>procedure when doing peri care on residents and proper disposal of soiled linens. These in-services were on 2/23/11 at 7:30 p.m. and 5:30 a.m., 2:00 p.m. on 2/24/11.</p> <p>How it will be monitored:</p> <p>The DON/Designee will complete handwashing/glove usage proficiencies for at least 5 staff members randomly, each day, to include all shifts for the next 30 days; and then 5 staff members randomly, to include all shifts on a weekly basis for 30 days; and then 5 staff members randomly, to include all shifts on a quarterly basis. Any deficiencies found will be corrected immediately, along with in-service.</p> <p>Results of proficiencies will be reviewed in daily QA stand-up meeting as completed and reviewed during Quarterly Quality Assurance Meeting with the Medical Director for on-going compliance.</p> <p>This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is: 3/01/11.</p>		

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	<p>guiding it in by holding the tube itself, rather than the exterior end.</p> <p>The facility Policy and Procedure, effective 6/20/03, for Clinical standards of tracheostomy care was reviewed on 2/22/11 at 9:00 A.M. It indicated the disposable inner cannula was to be replaced with a sterile inner cannula.</p> <p>The facility reference book provided at the nurses station was the Lippincott Manual of Nursing Practice 9th edition. It was reviewed on 2/22/11 at 9:44 A.M. The reference included procedures for routine trache care on page 227. Excerpts included: "...7. If disposable inner cannula is used, replace the new cannula...touching only the external portion to avoid contamination of the inner portion"</p> <p>On 2/16/10 at 8:15 A.M. CNA #1 and CNA #2 were observed caring for Resident #11. The CNAs had just finished cleaning incontinent BM from the resident. With the same contaminated gloves, CNA #1 was wiping mucous from around the trache site dressing, using a corner of the towel which had been in use for the pericare. When informed of the possibility of cross contamination she indicated she was not familiar with the</p>						

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	<p>care of the resident, and applied new gloves to her unwashed hands. CNA#2 used gloves for the pericare, handled Foley catheter tubing and bag and then, with the same gloves, repositioned the tubing of the respiratory misting unit and the mask over the trache.</p> <p>Later at 10:20 A.M. on the same day, the same 2 CNAs #1 and #2 cleansed Resident #11 of B.M. Both CNAs began caring for the resident without hand washing but after donning gloves. They cleansed the resident of BM and completed pericare. CNA#2 applied skin protestant with her right hand glove and changed only that glove, contaminating the new right hand glove with her left hand glove. The CNAs had dropped 2 to 3 wash cloths on the floor and picked them up, CNA #2 handed the gloves from the floor to CNA#1. With contaminated gloves, they continued care of the resident. CNA#2 rearranged the residents feeding tube and applied lotion to the resident's hands and arms and arranged the hair around the resident's face while CNA#1 handled the feeding tubes and hand of the resident.</p> <p>On 2/16/11 at 11:00 A.M. LPN#1 was observed preparing to change the feeding tube dressing of Resident #11. The LPN</p>						

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	<p>was carrying dressing supplies in one hand as she approached the resident's room. There was a house keeping cart blocking her entry to the doorway. The LPN moved the cart by holding inside rim of it's 3/4 full trash bin using both her hands and also contacting the packaged supplies she was holding in her right hand .She entered the room to change the feeding tube dressing and failed to wash hands. She got 2 clean gloves from the box and applied the left one. She held the second glove with her left hand while she used her bare, soiled, right hand to adjust the misting mask over the resident's trache site. She applied the right hand glove and removed the soiled dressing from around the feeding tube. She cleansed the area around the tube, applied a new dressing, taped the new dressing in place. She rummaged in her right side pocket ,which also held the med room keys until she found a roll of tape and an indelible felt tip marker. She dated the new dressing, disposed of trash. She washed her hands and then the cleaning agent, the tape and the felt marker in her pocket with her keys. She went into the med room, using the keys and put the cleaner in the resident's drawer and kept the tape and marker in her pocket. She got ear drops for Resident # 18 and went to that resident directly. Failing to hand wash, she</p>						

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	<p>applied gloves, instilled the drops and put the bottle in her right pocket with the keys and tape. She used hand sanitizer and then went back to the med room and put the bottle of drops from her pocket into that resident's drawer.</p> <p>The undated facility Hand Hygiene Guidelines Fact sheet was reviewed on 2/16/11 at 2:30 P.M. It included "The use of gloves does not eliminate the need for hand hygiene.</p> <p>The 1/07 facility Procedure for Dressing change was reviewed on 2/22/11 at 2:16 P.M. It included: "...1. Wash hands...4. Open dressing pack. 5. Put on first pair of disposable gloves. 6. Remove soiled dressing and discard in plastic bag. 7. Dispose of gloves in plastic bag. 8. Wash hands. 9. Put on second pair of gloves. 13. Apply dressings and secure. 14. Remove gloves and discard with all unused supplies in plastic bag. 16. Wash hands..."</p> <p>A.2. Resident #26's clinical record was reviewed on 2/11/11 at 8:40 A.M. His current diagnoses included but were not limited to: left ischium pressure ulcer and quadriplegia. His current Minimum Data Set Assessment (MDS) dated 1/18/11, included but was not limited to a non</p>						

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	<p>ambulatory status and upper and lower range of motion impairment bilaterally.</p> <p>On 2/16/11 at 9:05 A.M., LPN #1 and the Director of Nursing (DON) indicated they were to change the wound vac(vacuum) dressing. LPN #1 and the DON upon onset of procedure applied gloves without handwashing. LPN #1 began removing the plastic dressing of the left hip pressure sore. A moderate amount of green drainage was observed on the flat sheet of the bed. Resident #26 at this time had a large formed BM in an incontinent pad provided by the nurses. The incontinent pad with the BM was removed from the bed and incontinence care was provided. After incontinence care was provided both nurses removed their gloves. LPN #1 used a sanitizing gel and then both nurses applied new gloves without handwashing.</p> <p>The dressing change continued with LPN #1 using a wound cleanser, Carra Klensz at the wound site. LPN #1 removed the packing from the wound area. After the packing was removed LPN#1 removed her gloves and applied new gloves without handwashing.</p> <p>LPN #1 used a q-tip to pack the left hip wound with wound vac packing. A</p>						

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	<p>plastic wrap dressing was applied over the left wound area. After dressing completion LPN #1 and the DON applied a clean flat sheet to the mattress of the bed. The DON without a bag for the soiled linen placed the soiled sheet at the foot of the bed on the edge of the clean sheet until a bag for the soiled linen was obtained.</p> <p>On 2/17/11 at 9:00 A.M., the DON provided a policy entitled, "Dressing Change, Clean." This policy included but was not limited to: "...purpose: ... to prevent infection and spread of infection... procedure: 1. Wash hands 2. Place plastic bag near foot of bed to receive soiled dressings. 3. Create clean field. 4. Open dressing pack. 5. Put on first pair of disposable gloves. 6. Remove soiled dressing and discard in plastic bag. 7. Dispose of gloves in plastic bag. 8. Wash hands..."</p> <p>A.3. On 2/16/11 at 8:22 A.M., Resident #45's left and right hip pressure sore dressings were to be changed. LPN #2 and the Director of Nursing (DON) began the dressing change procedure by applying gloves without handwashing. After the procedure had started Physical Therapy staff member (PT staff #1) entered Resident #45's room and also</p>						

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	<p>applied gloves without handwashing.</p> <p>After LPN #2 removed the right hip dressing she applied clean gloves without handwashing. PT#1 using plastic wound measuring sheets measured the upper right hip area and then removed gloves and applied clean gloves. PT staff #1 then using a new plastic wound measuring sheet measured the right lower hip pressure sore.</p> <p>After the right pressure sore wound packing was applied by LPN #2, the DON and LPN #2 removed their gloves and applied clean gloves.</p> <p>LPN #2 then removed the Left hip pressure sore dressing and wound packing. LPN#2 then removed her gloves and without handwashing applied clean gloves. PT staff #1 measured the left hip pressure sore. PT staff #1 then removed her gloves and washed her hands in the resident's bathroom.</p> <p>LPN #2 with clean gloves on applied packing to the left hip wound area and then completed the dressing change.</p> <p>On 2/18/11 at 8:35 A.M., during interview with the DON, she indicated she was aware of the facility policy in regard to</p>						

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	<p>hand washing before dressing changes and after soiled dressings removed.</p> <p>B.1. On 2/16/11 at 11:25 A.M., LPN #2 brought IV supplies to Resident #45's room to administer the IV antibiotic Doribax (500 mg). LPN #2 applied clean gloves as the IV procedure began without handwashing. The IV antibiotic solution was prepared and primed from the pump ready for administration. LPN #2 removed her gloves and applied clean gloves to access the IV port site. At this time LPN #2 was made aware of handwashing lacking since IV procedure had begun. LPN #2 removed her gloves and entered the resident's bathroom and washed her hands before continuing with the IV procedure.</p> <p>On 2/18/11 at 8:35 A.M., during interview with the DON, she indicated she was aware of the facility IV policy in regard to handwashing procedures.</p> <p>On 2/17/11 at 1:05 P.M., the DON provided a facility policy for IV fluid/medication administration. The policy was entitled "Administration of an Intermittent Infusion (policy date 2008)." this policy included but was not limited to: "...Procedure: 1. Verify physician</p>						

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	<p>order. 2. Identify resident using appropriate identifiers. 3. Explain procedure to resident/significant other. 4. Wash hands. 5. Assess venous access site..."</p> <p>The Immediate Jeopardy began on 2/15/11 when the facility failed to ensure practices to prevent the spread of infection in regard to tracheostomy care. The Immediate Jeopardy was removed on 2/24/11 at 2:30 P.M. when through review of inservicing, care observation, and staff interview, it was determined that the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. Staff were aware of the infection control principles of when to wash hands in conjunction with glove use and when to change gloves prior to performing clean or sterile procedures as well as the principles of objects acting as carriers of infection. Staff were observed to adhere to the principles in practice. Ongoing monitoring of practice was being provided to ensure compliance.</p> <p>3.1-18(j) 3.1-18(l)</p>						

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